SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Safe & Effective Use of Benzodiazepines in Clinical Practice

May 31, 2017

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderator:

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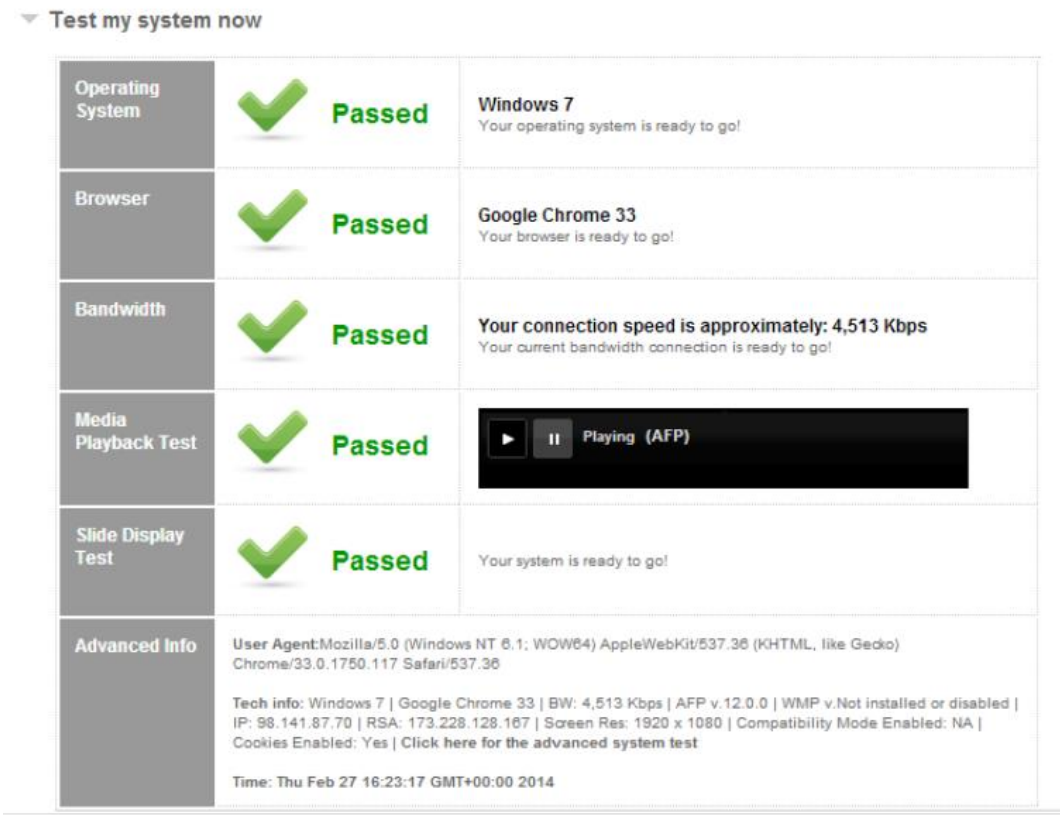

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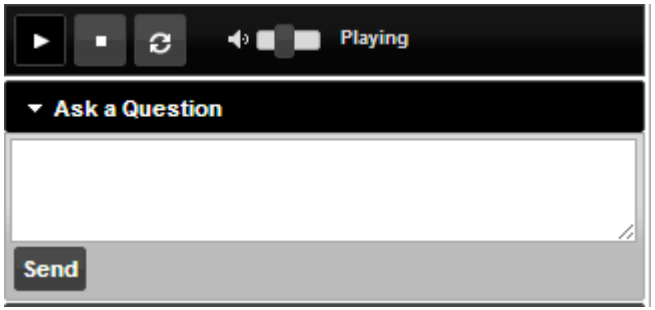

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Today's Speaker

Joe Parks, MD

Medical Director for The National Council for Behavioral Health

My Background

- Medical Director for National Council for Behavioral Health
- Practicing Psychiatrist in a Community Health Center
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
- Previously
  - Medicaid Director for Missouri
  - Medical Director Missouri Department of Mental Health

Learning Objectives

- Articulate the value of practice guidelines and the limitations of data regarding unsafe benzodiazepine use

- Identify key change processes and milestones for quality improvement projects focused on benzodiazepine prescribing

Overview

What is Anxiety?

What are the different types of anxiety disorders?

What are the causes?

What are the symptoms?

What are the treatments?

Professional Resources available

Definition of Anxiety

Anxiety is a feeling of apprehension or fear. The source of this uneasiness is not always known or recognized, which can add to the distress you feel.

Anxiety disorders are a group of psychiatric conditions that involve excessive anxiety.

Anxiety Facts

Most common mental illness in the U.S. with 19 million of the adult (ages 18 54) U.S. population affected.

Anxiety disorders cost more than $42 billion a year.

More than $22 billion are associated with the repeated use of healthcare services, as those with anxiety disorders seek relief for symptoms that mimic physical illnesses.

Anxiety is highly treatable (up to 90% of cases), but only one-third of those who suffer from it receive treatment

People with an anxiety disorder are three-to-five times more likely to go to the doctor and six times more likely to be hospitalized for psychiatric disorders than non-sufferers.

Depression often accompanies anxiety disorders

2003 Anxiety Disorders Association of America

Recent Studies

Freedom From Fear conducted a survey among 410 attendees during National Anxiety Disorders Screening Day on May 7, 2003. The results :

- An increase in physical aches and pains is directly attributed to anxiety disorders and depression

- 60%) of the respondents with undiagnosed medical conditions said that on days when they feel anxious or depressed, there is a moderate (41%) to severe (19%) change in their physical symptoms or aches and pains. These physical symptoms or aches and pains include backaches (13%), vague aches and pains (14%), headaches (14%), digestive pain (11%) and dizziness (8%).

- 50% of respondents with diagnosed medical conditions, such as arthritis, migraines, diabetes, heart and respiratory diseases, reported that on days when they feel anxious or depressed, there is a moderate (38%) to severe (12%) change in their physical symptoms or aches and pains.

Common Causes

There is no one cause for anxiety disorders. Several factors can play a role:

- Genetics
- Brain biochemistry
- Overactive "fight or flight" response
  - Can be caused by too much stress
- Life circumstances
- Personality
  - People who have low self-esteem and poor coping skills may be more prone

Certain drugs, both recreational and medicinal, can lead to symptoms of anxiety due to either side effects or withdrawal from the drug.

Certain medical conditions are commonly associated with a sense of anxiety. Examples include: thyroid conditions, adrenal and other tumors and pulmonary conditions.

Symptoms of Anxiety

Anxiety is an emotion often accompanied by various physical symptoms, including:

- Twitching or trembling
- Muscle tension
- Headaches
- Sweating
- Dry mouth
- Difficulty swallowing
- Abdominal pain (may be the only symptom of stress especially in a child)

Additional Symptoms of Anxiety

Sometimes other symptoms accompany anxiety:

- Dizziness
- Rapid or irregular heart rate
- Rapid breathing
- Diarrhea or frequent need to urinate
- Fatigue
- Irritability, including loss of your temper
- Sleeping difficulties and nightmares
- Decreased concentration
- Sexual problems

Social Effects of Anxiety

Depression

- Not as involved with family and friends the way you used to be
- Lowered quality of relationships
- Low energy
- Lack of motivation to do the things you once looked forward to doing

Unable to convey the person that you are

Fear and avoidance of situations where previous attacks occurred

Types of Anxiety Disorders

- Panic Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Phobias
- Generalized Anxiety Disorder

Specific Disorder Facts

Generalized Anxiety Disorder

- Women are twice as likely to be afflicted than men.
- Very likely to exist along with other disorders.

Obsessive Compulsive Disorder

- It is equally common among men and women.
- One third of afflicted adults had their first symptoms in childhood.

Panic Disorder

- Women are twice as likely to be afflicted than men.
- Occurs with major depression in very high rates.

2003 Anxiety Disorders Association of America

Specific Disorder Facts

Post Traumatic Stress Disorder

- Women are more likely to be afflicted than men.
- Rape is the most likely trigger of PTSD, 65% of men and 45.9% of women who are raped will develop the disorder.
- Childhood sexual abuse is a strong predictor of lifetime likelihood for developing PTSD.

Social Anxiety Disorder

- It is equally common among men and women.

Specific Phobia affects

- Women are twice as likely to be afflicted as men

2003 Anxiety Disorders Association of America

Anxiety Statistics

Anxiety Disorders
One-Year Prevalence (Adults)

	Percent	Population Estimate* (Millions)
Any Anxiety Disorder	**18.1**	**58,101,000**
Panic Disorder	**2.7**	**8,667,000**
Obsessive-Compulsive Disorder	**1.0**	**3,210,000**
Post-Traumatic Stress Disorder	**3.5**	**11,235,000**
Any Phobia	**6.8**	**21,828,000**
Generalized Anxiety Disorder	**3.1**	**9,951,000**

- Based on U.S. Census resident population estimate of 321 million, age 18-54
- Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.

Treatments

- Medications (Drug Therapy):
- Behavioral Therapy
- Cognitive Behavioral Therapy
- Psychodynamic Psychotherapy

History

The first benzodiazepine (benzo) was synthesized by an Austrian scientist named Dr. Leo Sternbach in the mid 1950's while working at Hoffman-La Roche. The new compound's potential as a pharmaceutical was not initially recognized, however, Dr. Sternbach's persistent research eventually uncovered it's efficacy as a tranquilizer. In 1959, chlordiazepoxide (Librium) was introduced as the first of many benzos to come. Just four years later, in 1963, diazepam (Valium) came on the market. Clinicians quickly recognized the potential of benzos as a safer alternative to the barbiturate class of anxiolytics.

Issues in General

Benzodiazepines

- One of the most commonly prescribed classes of psychotropic medications
- Benzodiazepine seeking is common and this challenges person centered treatment approaches

- In 2008, roughly 1 in 20 adults filled a BDZ Rx
  - Long Term use (120 day supply within 1 year)
    - Characteristic of 0.4% population ages 18-35
    - 2.7% populations ages 65-80
  - Vast majority of Rx written by non-psychiatrists

Olfson et al, 2015
Paulozzi et al, 2014
Dell'Osso et al, 2015

Issues in General

- BDZs - widely prescribed in almost all psychiatric conditions, as well as in many other medical disorders.
- Often prescription practices do not align with current evidence.
- Scientific literature provides conflicting recommendations regarding the continued role of BDZs in ongoing treatment, with varying interpretations of the benefits and risks associated with their prescription.
- Paucity of guidelines focusing specifically on BDZs
  - usually confined to disorder-specific treatment guidelines that very rarely provide specifics on dosage, selection of appropriate BDZ or specific length of treatment.
- All guidelines contend
  - prescribers should employ BDZs as primarily a short-term, stabilizing intervention
  - require significant monitoring of a range of possible adverse side-effects, including the potential for tolerance, dependency, rebound symptoms and withdrawal.

Dell'Osso et al, 2015

Clinical Applications

- Anxiolytic
  - GAD, PTSD, OCD, etc.
  - Panic Disorder
  - Specific Phobias
- Anticonvulsant
  - Status epilepticus
  - Myoclonic epilepsy
- Muscle relaxant
- Sleep aid
- Pre-operative anesthesia
- Alcohol withdrawal

Issues: Deleterious Effects

- Cognitive
- Psychomotor
- Disinhibitory
- Tolerance, Dependence and Withdrawal
- Abuse and Overdose
- Street Value

Benzos: Patterns of Use

45% of Use <30 days

80% of Use <4 months

15% of Use >12 months (7-18% Europe)

Women, twice the rate as men

<40% of Anxiety Diagnosis Treated

>40% of Panic Disorder Treated

Benzodiazepine Receptors

Type 1:

- **Most common throughout CNS, mediates SEDATION: Tolerance**

Type 2:

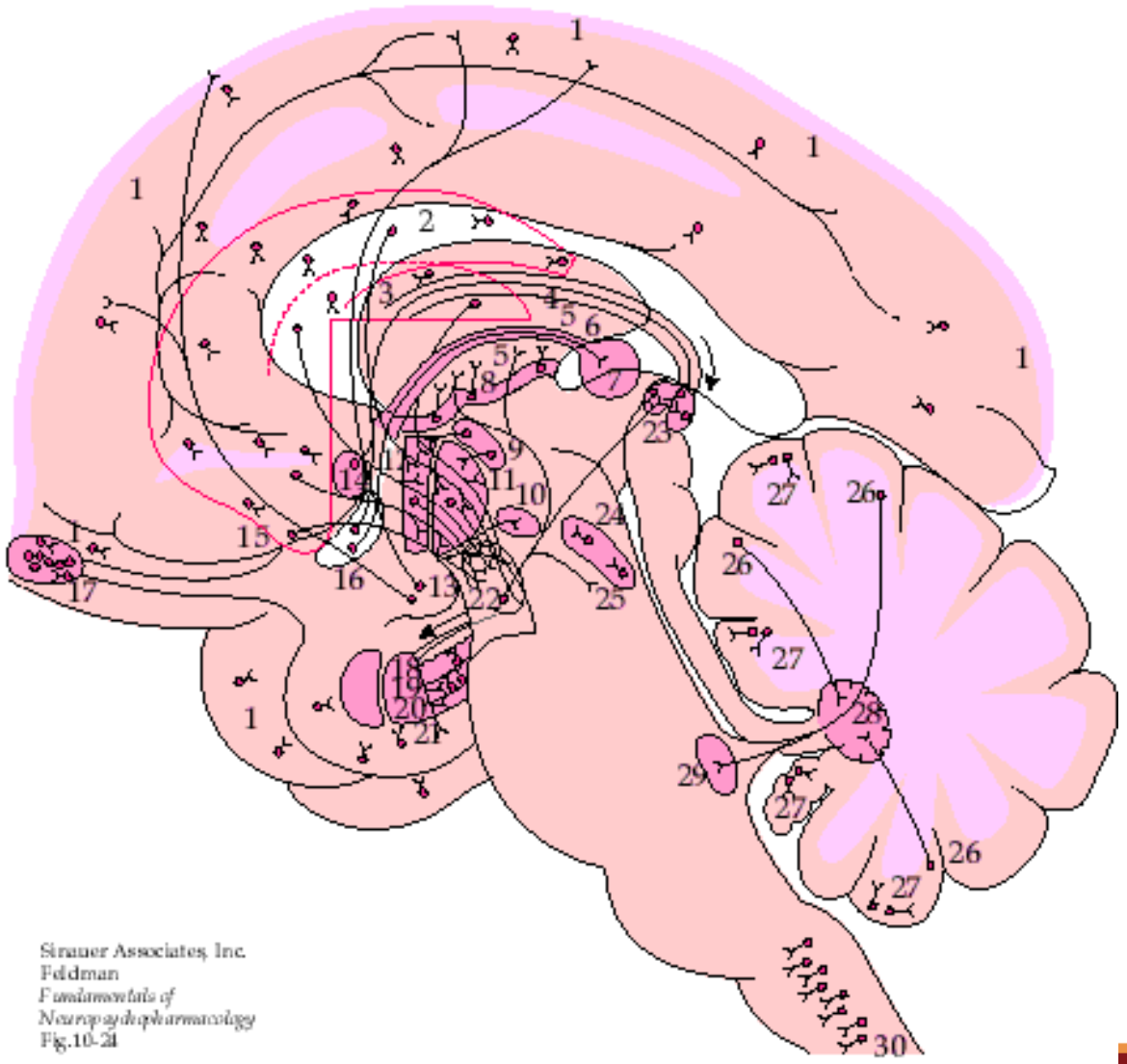
- **hippocampus, striatum, spinal cord, mediates <u>ANXIOLYSIS</u>**

Type 3:

- **Cerebellar granule cells**

GABA BRAIN CIRCUITRY

60 - 75% OF ALL BRAIN SYNAPSES ARE GABAERGIC – "natural tranquillizer"



BZD: Pharmacokinetics

Lipid-soluble: fast cross blood-brain-barrier: rapid onset of action.

- Persist longer in high fat-to-lean body mass
  - obese, elderly
- Abuse liability (Valium)

Biotransformation & Half-Life:

- Hepatic oxidation: long-t1/2, active metabolites
- Glucuronidation: short-t1/2, no active metab.

BZD: Interactions

CNS Depressants

p450 2C9

- **Diazepam, TCAs, Warfarin, phenitoin. (luvox inhibit)**

p450 3A4

- **triazolam, midazolam, alprazolam, CBZ, quinidine, terfenadine, erythromycin, (luvox, serzone inhibit)**

Disulfiram & Cimetidine ↑BZD levels

BZD: Adverse Effects

BZD vs other psychotropics have few SE

Sedation, CNS Depression

- Worse if combined with EtOH

Behavioral Disinhibition

- Irritable, excitement, aggression (<1%), rage

Psychomotor & Cognitive Impairment

- Coordination, attention (driving)
- Poor visual-spatial ability (not aware of it)
- Ataxia, confusion

BZD: Adverse Effects

Overdose: Rare fatalities if BZD alone

Severe CNS & Respiratory Depression if combined with:

- Alcohol
- Opiates
- Heroin
- Barbiturates
- Narcotics
- Tricyclic Antidepressants

Dependence and Withdrawal

Most people will become dependent after > 6 weeks continuous use

Only 30% of benzodiazepine dependent people ever get off them completely

Methadone patients at high risk of benzodiazepine abuse (25 - 65%)

BZD: Withdrawal

Worse if stop abruptly

Symptoms:

- GI Sx, Diaphoresis, ↑pulse, ↑BP
- Tremor, lethargy, dizziness, headaches
- Restlessness, insomnia, irritability, anxiety
- Depersonalization, perceptual disturbances

Also: depression, tinnitus, delirium, panic, hallucinations, abnormal muscular movs.

Seizures: Abrupt discount of short acting

Treatment: Long half-life benzo

Dependence/Withdrawal, cont.

- Rarely -seizures, delirium, confusion, psychosis
- Triggering of depression, mania, OCD
- 90% of long-term users (>8mo-1yr) experience significant withdrawal
- Insignificant wd if used less than 2 weeks
- Mild-moderate if used >8 weeks
- Slow taper (>30days) with +/- carbamazepine, valproic acid, trazodone, imipramine
- CBT effective in dc-ing benzos and controlling panic/anxiety

Predictors of severe withdrawal

- High-potency-quickly eliminated (e.g. alprazolam, lorazepam, triazolam)
- Higher daily dose
- More rapid rate of taper (esp last 50%)
- Diagnosis of panic disorder (not GAD)
- High pretaper levels of anxiety and depression
- ETOH or other substance dependence/abuse
- Personality pathology -e.g. neurotic or dependent
- Not motivated to discontinue use

Anxiety symptoms

Common to all anxiety:

- Agitation
- Panic attacks
- Agoraphobia
- Insomnia
- Nightmares
- Depression
- Poor memory
- Loss of concentration

Specific to withdrawal:

- Perceptual distortions, depersonalization
- Hallucinations (visual and auditory)
- Tingling and loss of sensation, formication (a feeling of ants crawling over the skin)
- Sensory hypersensitivity
- Muscle twitches and fasciculation
- Psychotic symptoms, confusion, convulsions (rare)

Why is it so hard to come off?

- Reducing causes increased excitation throughout the brain which causes the symptoms of withdrawal, including agitation, anxiety, and insomnia.

- The number of GABA receptors is slowly restored in response to benzodiazepine cessation or dose reduction.

- The rate of withdrawal of treatment needs to allow time for GABA receptors to regenerate if withdrawal symptoms are to be minimized.

Withdrawals depend on speed of reduction

Most people only experience mild withdrawal symptoms when withdrawal is slow and tapered to their needs [Ashton, 2002d].

Severe withdrawal symptoms are associated with the following [Kan et al, 2004]:

- Rapid withdrawal
- Prolonged use of benzodiazepines
- High-dose use
- Short-acting, potent benzodiazepines
- People with a history of anxiety problems

Withdrawal symptoms characteristically vary in severity and type from day to day and from week to week. As some symptoms resolve, others may take their place. These symptoms gradually become less severe and less frequent with time [Ashton, 2002d].

How long do symptoms last?

Up to 15% of people develop protracted withdrawal symptoms (months or years)

- Anxiety: Gradually diminishes over 1 year
- Insomnia: Gradually diminishes over 6–2 months
- Depression: May last a few months responds to antidepressants
- Cognitive impairment: Gradually improves, but may last for >1 year
- Perceptual symptoms: (e.g. tinnitus, paraesthesia, pain (usually in limbs) Gradually recedes, but may last for at least 1 year and occasionally persist indefinitely
- Motor symptoms: (e.g. muscle pain, weakness, tension, painful tremor, jerks) Usually gradually recede, but may last for >1 year
- Gastrointestinal symptoms: Gradually recede, but may last for at least 1 year and occasionally persist indefinitely

Common problems when detoxing

- Symptoms of depression
- Symptoms of anxiety
- Insomnia
- Worsening of pre-existing mental health problems
  - OCD
  - Panic attacks
  - Psychotic symptoms

What has been tried?

NO EVIDENCE for:

- Antipsychotics – makes it worse!!
- Antidepressants
- Buspirone

SOME evidence for:

- Propranolol
- Valproic acid

Suggested principles

- Where possible change to a long acting drug – usually diazepam
- Avoid extra medication
- Antidepressants only useful for clinical depression or panic attacks
- SUPPORT.. SUPPORT.. SUPPORT!
  - Family, friends, helplines, addiction or GP staff

Why use diazepam?

Withdrawal is most easily managed from diazepam because:

Diazepam and its metabolites (desmethyldiazepam and nordiazepam) have long half-lives (between 20 hours and 200 hours), which ensures a gradual fall in blood concentrations. The blood level of its longest active metabolite for each dose falls by a half in about 8 days [Micromedex, 2006]

Detox regimens

Be flexible in following the schedule

For people taking 40 mg per day of diazepam or less, a typical withdrawal schedule that is tolerated by most people would be to:

- Reduce by 2 mg to 4 mg every 1–2 weeks to 20 mg per day
- Reduce by 1 mg to 2 mg every 1–2 weeks to 10 mg per day
- Reduce by 1 mg every 1–2 weeks to 5 mg per day
- Reduce by 0.5 mg to 1 mg every 1–2 weeks until completely stopped.

Total withdrawal time from diazepam 40 mg per day might be 30 60 weeks; withdrawal from diazepam 20 mg per day might take 20 40 weeks.

Stopping the last few milligrams is often seen by patients as being particularly difficult but this is usually an unfounded fear derived from long-term psychological dependence on benzodiazepines.

Other Medications for Treating Anxiety

High Dose SSRI (40-60 mg fluoxetine or citalopram): shown to be effective but usually takes 3-4 weeks

Propranolol 20 to 40 mg b.i.d.: Blocks somatic symptoms of anxiety, effective immediately

Buspirone: shown to be effective but usually takes 3-4 weeks, particularly useful in elderly patients

Behavioral and Cognitive Therapy

- Teaches patient to react differently to situations and bodily sensations that trigger anxiety
- Teaches patient to understand how thinking patterns that contribute to symptoms
- Patients learn that by changing how they perceive feelings of anxiety, the less likely they are to have them
- Examples: Hyperventilating, writing down list of top fears and doing one of them once a week, spinning in a chair until dizzy; after awhile patients learned to cope with the negative feelings associated with them and replace them with positive ones

Psychodynamic Psychotherapy

- Psychodynamic therapy is a general name for therapeutic approaches which try to get the patient to bring to the surface their true feelings, so that they can experience them and understand them. Psychodynamic Psychotherapy uses the basic assumption that everyone has feelings held in the subconscious which are too painful to be faced. We then come up with defenses (such as denial) to protect us knowing about these painful feelings.

- Psychodynamic psychotherapy assumes that these defenses have gone wrong and are causing more harm than good, making you seek help. It tries to subdue them, with the intention that once you are aware of what is really going on in your mind the feelings will not be as painful.

- Takes an extremely long time and is labor intensive

Alternative and/or Complimentary Treatments

- Acupuncture
- Aromatherapy
- Breathing Exercises
- Exercise
- Meditation
- Nutrition and Diet Therapy
- Vitamins
- Self Love

Acupuncture

- Caused by the imbalance of chi coming about by keeping emotions in for too long
- Emotion effects the chi to move in an abnormal way: when fearful it goes to the floor, when angry, the neck and shoulders tighten
- Redirects the chi into a balanced flow, releases tension in the muscles, increases flow of blood, lymph, and nerve impulses to affected areas
- Takes 10-12 weekly sessions

Aromatherapy

- Calming Effect: vanilla, orange blossom, rose, chamomile, and lavender
- Reducing Stress: Lavender, sandalwood, and nutmeg
- Uplifting Oils: Bergamot, geranium, juniper, and lavender
- Essential Oil Combination: 3 parts lavender, 2 parts bergamot, and 1 part sandalwood

Exercise

Benefits: symbolic meaning of the activity, the distraction from worries, mastery of a sport, effects on self image, biochemical and physiological changes associated with exercise, symbolic meaning of the sport

Helps by expelling negative emotions and adrenaline out of your body in order to enter a more relaxed, calm state to deal with issues and conflicts

Meditation

Cultivates calmness to create a sense of control over life

Practice: Sit quietly in a position comfortable to you and take a few deep breaths to relax your muscles, next choose a calming phrase (such as “om” or that with great significance to you), silently repeat the word or phrase for 20 minutes

Nutrition and Diet Therapy

- **Foods to Eat:** whole grains, bananas, asparagus, garlic, brown rice, green and leafy veggies, soy products, yogurt
- **Foods to Avoid:** coffee, alcohol, sugar, strong spices, highly acidic foods, foods with white flour
- Keep a diary of the foods you eat and your anxiety attacks; after awhile you may be able to see a correlation
- East small, frequent meals

Vitamins

- B-Vitamins stabilize the body's lactate levels which cause anxiety attacks (B-6, B-1, B-3)
- Calcium (a natural tranquilizer) and magnesium relax the nervous system; taken in combination before bed improves sleep
- Vitamin C taken in large doses also has a tranquilizing effect
- Potassium helps with proper functioning of adrenal glands
- Zinc has a calming effect on the nervous system

Self Love

- The most important holistic treatment of all
- Laugh: be able to laugh at yourself and with others; increases endorphin levels and decreases stress hormones
- Let go of frustrations
- Do not judge self harshly: don’t expect more from yourself than you do others
- Accept your faults

Issues in Supervising Practice

Use of controlled substances (benzodiazepines and stimulants) not driven by diagnostic work and/or consideration of alternative treatments

- Knowledge
- Attitudes
- Skills

Lack of careful monitoring of dose, refills, medication response, use of (and engagement with) alternative treatments

- Time
- Team

Lack of identification of and intervention skills for

- Primary and comorbid Substance Use disorders
- Pain Disorders

Strategies

- Consensus Statements
- Guidelines
- Protocols
- Audits

- PDMP

Guidelines by Disorders

Anxiety Disorders

- Generalized Anxiety Disorder
- Panic Disorder
- Social Anxiety Disorder

Insomnia

Post Traumatic Stress Disorder

Obsessive Compulsive Disorder

Affective Disorders

Schizophrenia and other Psychotic Disorders

Borderline Personality Disorder

Alcohol Withdrawal

Guideline Sample
The Jewish Board, NY, NY

- Part of Psychiatry Manual, Guidelines for Use of Benzodiazepines within agency practice
- Created based upon consensus work at another Agency
- Created with internal feedback from:
  - Psychiatrists
  - Nurse Practitioners
  - CQI Staff
  - Directors
- In place since June 2015
- Initial feedback and utility…

Guideline Sample-
The Jewish Board, NY, NY

Generally agreed upon indications in psychiatry

1. anxiety: acute and chronic (especially PD, GAD, SAD)
2. acute insomnia
3. acute agitation particularly in mania and psychosis
4. alcohol withdrawal
5. akathisia
6. catatonia
7. co-prescription during initiation phase of antidepressant in PD and GAD
8. tremor

Guidelines Sample-
The Jewish Board, NY, NY

Disputed indications in psychiatry

1. Acute stress disorder
2. Posttraumatic stress disorder
3. Chronic insomnia

Guidelines Sample- The Jewish Board, NY, NY

Relative Contraindications

1.patients 65 years and older

2.current substance use disorder

3.history of substance use disorder

4.borderline Personality Disorder

5.co-prescription of opiate pain medications (especially methadone and suboxone)

6.clients with recent suicidal ideation and/or poor impulse control

Absolute Contraindications

1.active use of alcohol with unreliable reports about use and increasing requests for meds

Guidelines Sample-
The Jewish Board, NY, NY

Articulated Concerns

1. physiological dependence
2. heightened anxiety symptoms
3. falls (populations at risk include those 65 years and older, patients with diabetes, coprescription of antihypertensive medication and other medications that also can cause orthostasis)
4. driving impairments
5. memory interference
6. misuse and diversion
7. teratogenic effects
8. immediate post-partum effects on neonate

Guidelines Sample-
The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

1. Documentation of a clear rational for indications, balance of indications and contraindications
2. Indications for short term use of benzodiazepines should be documented, including a timeframe for review. Follow up is necessary and includes any indications of dependence or need for a discontinuation taper.
3. Indications for long term use of benzodiazepines should be documented, including use of (or consideration of) alternative interventions. Stability of dosing should be noted along with any indications of dependence or need for a discontinuation taper.

Guidelines Sample-
The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

4. Prn dosing should be used judiciously. Prn use and response should be carefully tracked and standing dosing reconsidered based upon use

5. Risks of use, including use of information obtained from i-STOP review.

6. Recommendations for combined psychopharm treatment with psychosocial interventions to manage anxiety, distress tolerance, insomnia and drug seeking behavior. These include Motivational Interviewing, Cognitive Behavioral Strategies and Mindfulness techniques.

Guidelines Sample-
The Jewish Board, NY, NY

Documentation standards when prescribing benzodiazepines

7. Use of code A (2-3 month supply)
8. Response to lost controlled substance prescriptions
9. Refill requests which occur before dosing runs out.

Sample: Protocol for Prescription of Benzodiazepines Joe Parks, MD, Director of MO HealthNet

1. For new patients reporting prior prescription treatment with benzodiazepines and requesting continuation

   a. obtain medical records from previous prescriber
   b. call all pharmacies where they have been filling benzodiazepines and verify and document pattern of refills for previous 12 months for all benzodiazepines- date of fill, medications, dosage, number dispensed, prescribing physician
   c. inquire with pharmacy if they are flagged as inappropriately drug seeking
   d. inquire with patient if they had been receiving benzodiazepines from more than one prescriber and/or telling him that more than one pharmacy in prior 12 months
   e. if patient has been using more than one prescriber and pharmacy in the previous six months or more than two pharmacies in prescribers in the previous 12 months obtain urine drug screen
   f. if they are a Medicaid patient check cyber access for benzodiazepines prescribing history, diagnoses of substance abuse/dependence
   g. obtain history of prior alcohol use/abuse, illegal drug use/abuse, prescription drug use/abuse

Sample: Protocol for Prescription of Benzodiazepines Joe Parks, MD

2. For current FHC patient requesting new start for benzodiazepines
    a. inquire with patient if they had been receiving benzodiazepines from any non-FHC prescribers
    b. call all pharmacies where they have been filling any medication and verify no benzodiazepines from other prescribers- inquire with each pharmacy if they are flagged as inappropriately drug seeking
    c. if patient has been using more than one prescriber and pharmacy in the previous six months or more than two pharmacies in prescribers in the previous 12 months obtain urine drug screen
    d. if they are a Medicaid patient check cyber access for benzodiazepines prescribing history, diagnoses of substance abuse/dependence
    e. obtain history of prior alcohol use/abuse, illegal drug use/abuse, prescription drug use/abuse

Sample: Protocol for Prescription of Benzodiazepines Joe Parks, MD

3. Safest and most effective utilization of benzodiazepines -benzodiazepines are most effective and safe when used for limited time and or on an intermittent PRN basis. When used as a standing daily dose indefinitely they will become ineffective for a substantial portion of patients.

a. time-limited for acute situational anxiety such as death of a loved one. Instruct the patient only to use the benzodiazepine as an intermittent PRN and not as a standing daily dose. Instruct the patient that the medication will not be continued indefinitely and set a time in the future by which you expect the medication to be discontinued of no more than three months
b. ongoing intermittent PRN usage. Intermittent PRN usage avoids development of tolerance and reinforces self-management of anxiety and worry. It is important to instruct patients that the medication is more effective if used intermittently and tends to become ineffective if taken as an ongoing daily dose. Example of this type of usage is Klonopin 0.5mg #10/month

Sample: Protocol for Prescription of Benzodiazepines Joe Parks, MD

4. I will not prescribe benzodiazepines for patients who have refused a trial of the usual recommended medications prior to taking benzodiazepines. I use the following medications prior to resorting to the benzodiazepines

a. high-dose SSRIs –
    a. Prozac 40 to 60 mg
    b. Celexa 40 to 60 mg - check EKG at 40 mg per QT prolongation and again at 60 mg continue therapy if QT interval is normal
b. low dose propranolol (20-40mg BID)for blocking autonomic symptoms of anxiety such as sweating ,palpitations, tremulous
c. buspirone with the target dose of 60 mg a day
d. hydroxyzine up to 100 mg TID
e. reduction/elimination of caffeine
f. increase of physical activity– “feeling anxious as a reminder that it's time to take a walk”

Sample: Protocol for Prescription of Benzodiazepines Joe Parks, MD

5. Refer to Dr. Parks when information above has been obtained and non-benzodiazepine options have been exhausted.

Additional Links

Anxiety Screening Tools

Anxiety Disorders Association of America (ADAA)

Freedom From Fear (www.freedomfromfear.org)

National Institute of Mental Health (www.nimh.nih.gov)

U.S. Dept. of Health & Human Services (http://www.mentalhealth.samhsa.gov/topics/explore/stress/)

Questions ?

CIHS Tools and Resources

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Please take a moment to provide your feedback by completing the survey at the end of today's webinar.